STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 91189-001**

v

Time Insurance Company
Respondent
_____/

Issued and entered
this 18th day of September 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On July 25, 2008, XXXXX, DC, authorized representative of XXXXX (Petitioner), filed a request for an external review with the Commissioner of the Office of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On August 4, 2008, after a preliminary review of the material submitted, the Commissioner accepted the case for external review.

The Commissioner notified Time Insurance Company (Time) of the external review and requested the information used in making its adverse determination.

The case involves medical issues so the Commissioner assigned the matter to an independent review organization (IRO) and requested the opinion of a medical expert. The IRO completed its review and sent recommendations to the Commissioner on August 18, 2008.

II
FACTUAL BACKGROUND

The Petitioner has health care coverage under a fully-insured individual policy with Time.

She received chiropractic care from XXXXX, DC, on December 12, 2007, January 7, 2008, February 13, 2008, and March 10, 2008.[1] Time denied coverage for the services as not medically necessary.

The Petitioner appealed the denial through Time's internal grievance process. After reviewing the claim, Time upheld its denial and issued a final adverse determination dated July 8, 2008.

III
ISSUE

Was Time correct in denying coverage for the Petitioner's chiropractic visits?

IV
ANALYSIS

Petitioner's Argument

The Petitioner saw Dr. XXXXX on November 6, 2007, with left buttock pain that she believed was the result of playing golf. Dr. XXXXX diagnosed "piriformis syndrome in conjunction with sacro-iliac misalignment." The Petitioner says she was treated for three visits with great success.

The Petitioner presented to Dr. XXXXX again in February 2008. This time she complained of neck pain that she thought must have been caused by something she did in her sleep. She was treated for three visits (February 13, March 10, and March 31, 2008) and says she noticed an increased range of motion and a pain level of 4/10.

The Petitioner believes the chiropractic services that Time denied were medically necessary and should be covered.

Time Insurance Company's Argument

Time denied coverage for the four chiropractic visits on the grounds that they were not medically necessary. The Petitioner's policy defines "medically necessary" as:

> Treatment, services or supplies that are rendered to diagnose or treat a

1 The Petitioner received chiropractic care both before and after these dates but only these dates of service were denied in Time's final adverse determination and are at issue in this external review.

> Sickness or an Injury. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Covered Person's Immediate Family Member. We must determine that such care:
>
> 1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury; and
>
> 2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
>
> 3. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or Injury; and
>
> 4. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.
>
> The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make the treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this plan.

Time, in the final adverse determination, explained the rationale for its denial:

> Treatment was provided on an ongoing basis from or before January 18, 2007 for complaints of generalized pain subjectively rated 4/10. The records do not include a detailed medical history or a detailed clinical examination. Daily notes are brief and do not include detailed subjective or clinical information. The initial treatment plan called for six months of treatment. Ongoing care cannot reasonably be expected to contribute substantially to the improvement of a condition resulting from an illness or injury. Therefore, treatment from December 7, 2007 through March 10, 2008 was not medically necessary.

Time believes its decision to deny coverage was correct.

Commissioner's Review

Since this case involved a medical issue it was assigned to an IRO to determine if the chiropractic care provided from December 7, 2007, through March 10, 2008, was medically necessary. The IRO reviewer is a licensed chiropractor; a diplomate of the National Board of Chiropractic Examiners; a certified chiropractic insurance consultant; a member of the Foundation for Chiropractic Education and Research; and is in active practice.

The IRO reviewer said medical necessity was not established for chiropractic care for the dates at issue. The IRO reviewer explained:

> This reviewer can find no evidence to support medical necessity for these visits. The third criterion [in Time's definition of medical necessity] listed above stating "…expected to result in or contribute substantially to the improvement of a condition" is not fulfilled in this case. There is no evidence in the notes reviewed that indicated improvement. In a two (2) year period, the enrollee continues to be treated in the same areas. The fourth criterion [in Time's definition of medical necessity] is also not met in this enrollee's case. "…is provided in the most conservative manner or least intensive setting without adversely affecting the condition or the quality of medical care provided." A two (2) year period of adjustment to the cervical, the dorsal, and the lumbar regions repeatedly, with no signs of objective improvement, does not indicate that this is the most conservative manner. No reassignments were made, no referrals were made and x-rays or further imaging or diagnostic studies were not suggested.
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> * * *
>
> In summary, the physician's records do not indicate any substantial prior history that would contribute to continued care. We have no idea as to the enrollee's age, sex, or type of employment if employed at all. Records that could substantiate the need for continuing care are illegible and undecipherable. While we could expect re-assessments to point the way for the enrollee's continuing care at six (6) week intervals, there is no indication that any re-assessment was performed through a two (2) year period, and the enrollee appears to have received continuous manipulation with no indication of improvement or regression.

The IRO reviewer concluded:

> It is the determination of this reviewer that medical necessity was not established for chiropractic services from December 7, 2007 through March 10, 2008 based on the documentation submitted for review.

The IRO reviewer's recommendation is based on extensive expertise and professional judgment and the Commissioner finds no reason to reject it. Therefore, the Commissioner accepts the IRO reviewer's conclusion and finds that the medical necessity for the Petitioner's chiropractic services from December 7, 2007, through March 10, 2008, has not been established.

V
ORDER

The Commissioner upholds Time Insurance Company's final adverse determination of July 8, 2008. Time is not required to provide coverage for the Petitioner's chiropractic care for the

period December 7, 2007, through March 10, 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.